



Compensation and Pension Record Interchange (CAPRI)

CAPRI Compensation and Pension Worksheet Module (CPWM) Templates and AMIE Worksheet Disability Benefits Questionnaires (DBQs)

Release Notes Patch: DVBA*2.7*166

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Management & Financial Systems

Preface

Purpose of the Release Notes

The Release Notes document describes the new features and functionality of patch DVBA*2.7*166. (CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQs).

The information contained in this document is not intended to replace the CAPRI User Manual. The CAPRI User Manual should be used to obtain detailed information regarding specific functionality.

Table of Contents

1.	Purpose.....	1
2.	Overview	1
3.	Associated Remedy Tickets & New Service Requests	1
4.	Defects Fixes	1
5.	Enhancements	2
5.1	CAPRI – DBQ Template Additions.....	2
5.2	CAPRI – DBQ Template Modifications	2
5.3	CAPRI DBQs Deactivated.....	4
5.4	AMIE–DBQ Worksheet Additions	4
5.5	AMIE–DBQ Worksheet Modifications	4
6.	Disability Benefits Questionnaires (DBQs).....	5
6.1.	Hearing Loss and Tinnitus Disability Benefits Questionnaire	5
6.2.	Hematologic and Lymphatic Conditions, including Leukemia Disability Benefits Questionnaire.....	11
6.3.	Persian Gulf and Afghanistan Infectious Diseases Disability Benefits Questionnaire.....	16
6.4.	Tuberculosis Disability Benefits Questionnaire	19
6.5.	Eating Disorders Disability Benefits Questionnaire.....	23
6.6.	Medical Opinion Disability Benefits Questionnaire.....	25
7.	Software and Documentation Retrieval.....	28
7.1	Software.....	28
7.2	User Documentation	28
7.3	Related Documents.....	28

1. Purpose

The purpose of this document is to provide a high-level overview of user and technical information of the enhancements specifically designed for Patch DVBA*2.7*166.

Patch DVBA *2.7*166 (CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQs) introduces enhancements and updates made to the AUTOMATED MED INFO EXCHANGE (AMIE) V 2.7 package and the Compensation & Pension Record Interchange (CAPRI) application in support of the new Compensation and Pension (C&P) Disability Benefits Questionnaires (DBQs).

2. Overview

Veterans Benefits Administration Veterans Affairs Central Office (VBAVACO) has approved implementation of the following new Disability Benefits Questionnaires:

- **DBQ Hearing Loss and Tinnitus**
- **DBQ Hematologic and Lymphatic Conditions Including Leukemia**
- **DBQ Persian Gulf and Afghanistan Infectious Diseases**
- **DBQ Tuberculosis**
- **DBQ Eating Disorders**
- **DBQ Medical Opinion**

Patch DVBA*2.7*166 will also include the deactivation of the following three DBQs that were previously released in Patch DVBA*2.7*161.

- **DBQ Initial PTSD (Deactivated)**
- **DBQ Review PTSD (Deactivated)**
- **DBQ Mental Disorders (Deactivated)**

3. Associated Remedy Tickets & New Service Requests

There are no Remedy tickets or New Service Requests associated with patch DVBA*2.7*166.

4. Defects Fixes

There are no CAPRI DBQ Templates or AMIE – DBQ Worksheet defects fixes associated with patch DVBA*2.7*166.

5. Enhancements

This section provides an overview of the modifications and primary functionality that will be delivered in Patch DVBA*2.7*166.

5.1 CAPRI – DBQ Template Additions

This patch includes adding four new CAPRI DBQ Templates that are accessible through the Compensation and Pension Worksheet Module (CPWM) of the CAPRI GUI application.

- **DBQ HEARING LOSS AND TINNITUS**
- **DBQ PERSIAN GULF AND AFGHANISTAN INFECTIOUS DISEASES**
- **DBQ TUBERCULOSIS**
- **DBQ MEDICAL OPINION**

5.2 CAPRI – DBQ Template Modifications

This patch includes updates made to the following CAPRI DBQ templates approved by the Veterans Benefits Administration Veterans Affairs Central Office (VBAVACO).

Modifications implemented with this patch include updating the following DBQs listed below. Each DBQ lists the changes that were made with this patch.

5.2.1. DBQ HEMATOLOGIC AND LYMPHATIC CONDITIONS INCLUDING LEUKEMIA

5.2.1.1 Section 1 Diagnosis: removed the rationale logic and added the (check all that apply) option:

Does the Veteran now have or has he/she ever been diagnosed with a hematologic or lymphatic condition?
☐ Yes ☐ No

If yes, select the Veteran's condition(s) (check all that apply):

<input type="checkbox"/> Acute lymphocytic leukemia (ALL)	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Acute myelogenous leukemia (AML)	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Chronic myelogenous leukemia (CML)	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Chronic lymphocytic leukemia (CLL)	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Hodgkin's disease	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Non-Hodgkin's lymphoma	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Multiple myeloma	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Myelodysplastic syndrome	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Plasmacytoma	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> Anemia (such as anemia of chronic disease, aplastic anemia, hemolytic anemia, iron or vitamin-deficient anemias, thalassemias, myelophthisic anemia, etc.)	ICD code: _____	Date of diagnosis: _____

- | | | |
|---|-----------------|--------------------------|
| <input type="checkbox"/> Thrombocytopenia | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Polycythemia vera | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Sickle cell anemia | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Splenectomy | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Hairy cell or other B-cell leukemia: If checked, complete Hairy cell and other B-cell leukemias Questionnaire in lieu of this Questionnaire. | | |
| <input type="checkbox"/> Other, specify: _____ | | |

5.2.1.2 Section 9 Other pertinent physical findings, complications, conditions, signs and/or symptoms: updated option (a) and added new option (b):

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis s_____ section above?

☐ Yes ☐ No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

☐ Yes ☐ No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms?

☐ Yes ☐ No

If yes, describe (brief summary): _____

5.2.2. DBQ EATING DISORDERS

5.2.2.1. First paragraph Introduction NOTE section contains the following new changes:

- VA Suicide Prevention Hotline has been changed to Veterans Crisis Line
- Stay on the Hotline has been changed to Stay on the Crisis Line

NOTE: If the Veteran experiences a mental health emergency during the interview, please terminate the interview and obtain help, using local resources as appropriate. You may also contact the Veterans Crisis Line at 1-800-273-TALK(8255). Stay on the Crisis Line until help can link the Veteran to emergency care.

5.2.2.2. Section 1 Diagnosis: removed the rationale logic and contains the following:

Does the Veteran now have or has he/she ever been diagnosed with an eating disorder(s)?

☐ Yes ☐ No

If yes, check all diagnoses that apply:

☐ Bulimia

Date of diagnosis: _____

ICD code: _____

Name of diagnosing facility or clinician: _____

☐ Anorexia

Date of diagnosis: _____

ICD code: _____

Name of diagnosing facility or clinician: _____

☐ Eating disorder not otherwise specified

Date of diagnosis: _____
ICD code: _____
Name of diagnosing facility or clinician: _____

5.2.2.3. Section 2 Medical History has been added and contains the following:

Describe the history (including onset and course) of the Veteran's eating disorder (brief summary):

5.2.2.4. Section 3 Findings was previously Section 2 Findings.

5.2.2.5. Section 4 Other symptoms was previously Section 3 Other symptoms.

5.2.2.6. Section 5 Functional impact was previously Section 4 Functional impact.

5.3 CAPRI DBQs Deactivated

VBAVACO has approved deactivation for the following three DBQs:

- **DBQ INITIAL PTSD**
- **DBQ REVIEW PTSD**
- **DBQ MENTAL DISORDERS**

5.4 AMIE–DBQ Worksheet Additions

VBAVACO has approved the following new AMIE –DBQ Worksheets that are accessible through the Veterans Health Information Systems and Technology Architecture (Vista) AMIE software package.

- **DBQ HEARING LOSS AND TINNITUS**
- **DBQ PERSIAN GULF AND AFGHANISTAN INFECTIOUS DISEASES**
- **DBQ TUBERCULOSIS**
- **DBQ MEDICAL OPINION**

This patch implements the new content for the AMIE C&P Disability Benefit Questionnaire worksheets, which are accessible through the VISTA AMIE software package.

5.5 AMIE–DBQ Worksheet Modifications

VBAVACO has approved modifications for the following AMIE –DBQ Worksheets.

- **DBQ HEMATOLOGIC AND LYMPHATIC CONDITIONS INCLUDING LEUKEMIA**
- **DBQ EATING DISORDERS**

6. Disability Benefits Questionnaires (DBQs)

The following section illustrates the content of the new questionnaires included in Patch DVBA*2.7*166.

6.1. Hearing Loss and Tinnitus Disability Benefits Questionnaire

Name of patient/Veteran: _____ SSN: _____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

NOTE: This form is only for use by VHA staff or contract examiners.

This exam is for:

- ☐ Tinnitus only (audiologist or non-audiologist clinician)
If this exam is for tinnitus only, complete section 2 only. Otherwise complete entire form.
- ☐ Hearing loss and/or tinnitus (audiologist, performing current exam)
- ☐ Hearing loss and/or tinnitus (audiologist or non-audiologist clinician, using audiology report of record that represents Veteran's current condition)
If using audiology report of record, date audiology exam was performed: _____

SECTION 1: HEARING LOSS (HL)

Note: All testing must be conducted in accordance with the following instructions to be valid for VA disability evaluation purposes.

Instructions: An examination of hearing impairment must be conducted by a state-licensed audiologist and must include a controlled speech discrimination test (specifically, the Maryland CNC recording) and a puretone audiometry test in a sound isolated booth that meets American National Standards Institute standards (ANSI S3.1.1999 [R2004]) for ambient noise. Measurements will be reported at the frequencies of 500, 1000, 2000, 3000, and 4000 Hz.

The examination will include the following tests: Puretone audiometry by air conduction at 250, 500, 1000, 2000, 3000, 4000, 6000 Hz and 8000 Hz, and by bone conduction at 250, 500, 1000, 2000, 3000, and 4000 Hz, spondee thresholds, speech discrimination using the recorded Maryland CNC Test, tympanometry and acoustic reflex tests (ipsilateral and contralateral), and, when necessary, Stenger tests. Bone conduction thresholds are measured when the air conduction thresholds are poorer than 15 dB HL. A modified Hughson-Westlake procedure will be used with appropriate masking. A Stenger must be administered whenever puretone air conduction thresholds at 500, 1000, 2000, 3000, and 4000 Hz differ by 20 dB or more between the two ears.

Maximum speech discrimination will be reported with the 50 word VA approved recording of the Maryland CNC test. The starting presentation level will be 40 dB re SRT. If necessary, the starting level will be adjusted upward to obtain a level at least 5 dB above the threshold at 2000 Hz, if not above the patient's tolerance level.

The examination will be conducted without the use of hearing aids. Both ears must be examined for hearing impairment even if hearing loss in only one ear is at issue.

When speech discrimination is 92% or less, a performance intensity function must be obtained.

A comprehensive audiological evaluation should include evaluation results for puretone thresholds by air and bone conduction (500-8000 Hz), speech reception thresholds (SRT), speech discrimination scores, and acoustic immittance with acoustic reflexes (ipsilateral and contralateral reflexes). Tests for non-organicity must be performed when indicated.

1. Objective Findings

a. Puretone thresholds in decibels (air conduction):

Instructions: Measure and record puretone threshold values in decibels at the indicated frequencies (air conduction). Report the decibel value, which ranges from - 10 dB to 105 dB, for each of the frequencies. Add a plus behind the decibel value when a maximum value has been reached with a failure of response from the Veteran. In those circumstances where the average includes a failure of response at either the maximum allowable limit (105 dB) or the maximum limits of the audiometer, use this maximum decibel value of the failure of response in the puretone threshold average calculation.

If the Veteran could not be tested (CNT), enter CNT and state the reason why the Veteran could not be tested. Clearly inaccurate, invalid or unreliable test results should not be reported.

The puretone threshold at 500 Hz is not used in calculating the puretone threshold average for evaluation purposes but is used in determining whether or not for VA purposes, hearing impairment reaches the level of a disability. The puretone threshold average requires the decibel levels of each of the required frequencies (1000 Hz, 2000 Hz, 3000 Hz, and 4000 Hz) be recorded for the test to be valid for determination of a hearing impairment.

RIGHT EAR

A	B	C	D	E	F	G	
500 Hz*	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz	8000 Hz	Avg Hz (B – E) **

LEFT EAR

A	B	C	D	E	F	G	
500 Hz*	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz	8000 Hz	Avg Hz (B – E) **

*The puretone threshold at 500 Hz is not used in determining the evaluation but is used in determining whether or not a ratable hearing loss exists.

**The average of B, C, D, and E.

***CNT – Could Not Test

b. Were there one or more frequency(ies) that could not be tested?

☐ Yes ☐ No

If yes, enter CNT in the box for frequency(ies) that could not be tested, and explain why testing could not be done: _____

c. Validity of puretone test results:

- ☐ Test results are valid.
☐ Test results are invalid (not indicative of organic hearing loss).

If invalid, provide reason: _____

d. Speech Discrimination Score (Maryland CNC word list)

Instructions on pausing: Examiners should pause when necessary during speech discrimination tests, in order to give the Veteran sufficient time to respond. This will ensure that the test results are based on actual hearing loss rather than on the effects of other problems that might slow a Veteran's response. There are a variety of problems that might require pausing, for example, the presence of cognitive impairment. It is up to the examiner to determine when to use pausing and the length of the pauses.

RIGHT EAR	%
LEFT EAR	%

e. Appropriateness of Use of Speech Discrimination Score (Maryland CNC word list)

- ☐ Use of speech discrimination score is appropriate for this Veteran.
☐ The use of the speech discrimination score is not appropriate for this Veteran because of language difficulties, cognitive problems, inconsistent speech discrimination scores, etc., that make combined use of puretone average and speech discrimination scores inappropriate.

f. Audiologic Findings

Summary of Immittance (Tympanometry) Findings:

	RIGHT EAR		LEFT EAR	
Acoustic immittance	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>
Ipsilateral Acoustic Reflexes	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>
Contralateral Acoustic Reflexes	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>
Unable to obtain/maintain seal	<input type="checkbox"/>		<input type="checkbox"/>	

2. Diagnosis

RIGHT EAR

- ☐ Normal hearing
☐ Sensorineural hearing loss (in the frequency range of 500-4000 Hz)* ICD code: _____
☐ Sensorineural hearing loss (in the frequency range of 6000 Hz or higher frequencies) ** ICD code: _____
☐ Significant changes in hearing thresholds in service***
☐ Conductive hearing loss ICD code: _____
☐ Mixed hearing loss ICD code: _____

LEFT EAR

- ☐ Normal hearing
☐ Sensorineural hearing loss (in the frequency range of 500-4000 Hz)* ICD code: _____
☐ Sensorineural hearing loss (in the frequency range of 6000 Hz or higher frequencies) ** ICD code: _____
☐ Significant changes in hearing thresholds in service***

- ☐ Conductive hearing loss
☐ Mixed hearing loss

ICD code: _____

ICD code: _____

NOTES:

*The Veteran may have hearing loss at a level that is not considered to be a disability for VA purposes. This can occur when the auditory thresholds are greater than 25 dB at one or more frequencies in the 500-4000 Hz range.

** The Veteran may have impaired hearing, but it does not meet the criteria to be considered a disability for VA purposes. For VA purposes, the diagnosis of hearing impairment is based upon testing at frequency ranges of 500, 1000, 2000, 3000, and 4000 Hz. If there is no HL in the 500-4000 Hz range, but there is HL above 4000 Hz, check this box.

***The Veteran may have a significant change in hearing threshold in service, but it does not meet the criteria to be considered a disability for VA purposes. (A significant change in hearing threshold may indicate noise exposure or acoustic trauma.)

3. Evidence review

In order to provide an accurate medical opinion, the Veteran's records should be reviewed, if available.

Was the Veteran's VA claims file reviewed?

- ☐ Yes ☐ No

If yes, list any records that were reviewed but were not included in the Veteran's VA claims file:

If no, check all records reviewed as part of this examination:

- ☐ Military service treatment records
☐ Military service personnel records
☐ Military enlistment examination
☐ Military separation examination
☐ Military post-deployment questionnaire
☐ Department of Defense Form 214 Separation Documents
☐ Veterans Health Administration medical records (VA treatment records)
☐ Civilian medical records
☐ Interviews with collateral witnesses (family and others who have known the Veteran before and after military service)
☐ Prior audiology reports
☐ Other: _____
☐ No records were reviewed

4. Etiology

If present, is the Veteran's hearing loss at least as likely as not (50% probability or greater) caused by or a result of an event in military service?

- ☐ Yes
☐ No

Rationale (Provide rationale for either a yes or no answer): _____

☐ Cannot provide a medical opinion regarding the etiology of the Veteran's hearing loss without resorting to speculation

Provide rationale for reason speculation required: _____

Did hearing loss exist prior to the service?

- ☐ Yes
☐ No

If yes, was the pre-existing hearing loss aggravated beyond normal progression in military service?

Right ear ☐ Yes ☐ No
Left ear ☐ Yes ☐ No
Provide rationale for both yes or no: _____

5. Functional impact of hearing loss

NOTE: Ask the Veteran to describe in his or her own words the effects of disability (i.e. the current complaint of hearing loss on occupational functioning and daily activities). Document the Veteran's response without opining on the relationship between the functional effects and the level of impairment (audiogram) or otherwise characterizing the response. Do not use handicap scales.

Does the Veteran's hearing loss impact ordinary conditions of daily life, including ability to work?
☐ Yes ☐ No

If yes, describe impact in the Veteran's own words: _____

6. Remarks, if any, pertaining to hearing loss: _____

SECTION 2: TINNITUS

1. Medical history

Does the Veteran report recurrent tinnitus?
☐ Yes ☐ No

Date and circumstances of onset of tinnitus: _____

2. Evidence review

In order to provide an accurate medical opinion, the Veteran's records should be reviewed, if available.

Was the Veteran's VA claims file reviewed?
☐ Yes ☐ No

If yes, list any records that were reviewed but were not included in the Veteran's VA claims file:

If no, check all records reviewed as part of this examination:

- ☐ Military service treatment records
- ☐ Military service personnel records
- ☐ Military enlistment examination
- ☐ Military separation examination
- ☐ Military post-deployment questionnaire
- ☐ Department of Defense Form 214 Separation Documents
- ☐ Veterans Health Administration medical records (VA treatment records)
- ☐ Civilian medical records
- ☐ Interviews with collateral witnesses (family and others who have known the Veteran before and after military service)
- ☐ Prior audiology reports
- ☐ Other: _____
- ☐ No records were reviewed

3. Etiology of tinnitus

a. Tinnitus associated with hearing loss

☐ The Veteran has a diagnosis of hearing loss according to VA criteria, and his or her tinnitus is at least as likely as not (50% probability or greater) a symptom associated with the hearing loss, as tinnitus is known to be a symptom associated with hearing loss

☐ The Veteran's tinnitus is not likely a symptom associated with Veteran's hearing loss, as Veteran does not have hearing loss according to VA criteria

b. Tinnitus not associated with hearing loss

NOTE: Select answer below and provide rationale.

The Veteran's tinnitus is:

☐ At least as likely as not (50% probability or greater) caused by or a result of military noise exposure
Rationale: _____

☐ At least as likely as not (50% probability or greater) due to a known etiology (such as traumatic brain injury)
Etiology and rationale: _____

☐ Not caused by or a result of military noise exposure
Rationale: _____

☐ Cannot provide a medical opinion regarding the etiology of the Veteran's tinnitus without resorting to speculation
Reason speculation required: _____

4. Functional impact of tinnitus

NOTE: Ask the Veteran to describe in his or her own words the effects of disability (i.e. the current complaint of tinnitus on occupational functioning and daily activities). Document the Veteran's response without opining on the relationship between the functional effects and the level of impairment (audiogram) or otherwise characterizing the response. Do not use handicap scales.

Does the Veteran's tinnitus impact ordinary conditions of daily life, including ability to work?

☐ Yes ☐ No

If yes, describe impact in the Veteran's own words: _____

5. Remarks, if any, pertaining to tinnitus: _____

Audiologist/clinician signature: _____ Date: _____

Audiologist/clinician printed name: _____

State audiology/examiner license #: _____ Physician address: _____

Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

6.2. Hematologic and Lymphatic Conditions, including Leukemia Disability Benefits Questionnaire

Name of patient/Veteran: _____ SSN: _____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with a hematologic or lymphatic condition?

☐ Yes ☐ No

If yes, select the Veteran's condition(s) (check all that apply):

- | | | |
|--|-----------------|--------------------------|
| <input type="checkbox"/> Acute lymphocytic leukemia (ALL) | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Acute myelogenous leukemia (AML) | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Chronic myelogenous leukemia (CML) | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Chronic lymphocytic leukemia (CLL) | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Hodgkin's disease | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Non-Hodgkin's lymphoma | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Multiple myeloma | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Myelodysplastic syndrome | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Plasmacytoma | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Anemia (such as anemia of chronic disease, aplastic anemia, hemolytic anemia, iron or vitamin-deficient anemias, thalassemias, myelophthistic anemia, etc.) | | |
| | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Thrombocytopenia | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Polycythemia vera | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Sickle cell anemia | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Splenectomy | ICD code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Hairy cell or other B-cell leukemia: If checked, complete Hairy cell and other B-cell leukemias Questionnaire in lieu of this Questionnaire. | | |
| <input type="checkbox"/> Other, specify: | | |

Other diagnosis #1: _____

ICD code: _____

Date of diagnosis: _____

Other diagnosis #2: _____

ICD code: _____

Date of diagnosis: _____

Other diagnosis #3: _____

ICD code: _____

Date of diagnosis: _____

If there are additional diagnoses that pertain to hematologic or lymphatic conditions, list using above format:

2. Medical history

a. Describe the history (including onset and course) of the Veteran's hematologic or lymphatic condition (brief summary): _____

b. Is continuous medication required for control of a hematologic or lymphatic condition, including anemia or thrombocytopenia caused by treatment for a hematologic or lymphatic condition?

☐ Yes ☐ No

If yes, list only those medications required for control of the Veteran's hematologic or lymphatic condition, including anemia or thrombocytopenia caused by treatment for a hematologic or lymphatic condition. Provide the name of the medication and the condition the medication is used to treat: _____

c. Indicate the status of the primary hematologic or lymphatic condition:

- ☐ Active
☐ Remission
☐ Not applicable

3. Treatment

a. Has the Veteran completed any treatment or is the Veteran currently undergoing any treatment for any hematologic or lymphatic condition, including leukemia?

☐ Yes ☐ No; watchful waiting

If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):

- ☐ Treatment completed; currently in watchful waiting status
☐ Bone marrow transplant
If checked, provide:
Date of hospital admission and location: _____
Date of hospital discharge after transplant: _____
☐ Surgery
If checked, describe: _____
Date(s) of surgery: _____
☐ Radiation therapy
Date of most recent treatment: _____
Date of completion of treatment or anticipated date of completion: _____
☐ Antineoplastic chemotherapy
Date of most recent treatment: _____
Date of completion of treatment or anticipated date of completion: _____
☐ Other therapeutic procedure
If checked, describe procedure: _____
Date of most recent procedure: _____
☐ Other therapeutic treatment
If checked, describe treatment: _____
Date of completion of treatment or anticipated date of completion: _____

4. Anemia and thrombocytopenia (primary, secondary, idiopathic and immune)

Does the Veteran have anemia or thrombocytopenia, including that caused by treatment for a hematologic or lymphatic condition?

☐ Yes ☐ No

If yes, complete the following:

a. Does the Veteran have anemia?

☐ Yes ☐ No

If yes, is the anemia caused by treatment for another hematologic or lymphatic condition?

☐ Yes ☐ No

If yes, provide the name of the other hematologic or lymphatic condition causing the secondary anemia:

b. Does the Veteran have thrombocytopenia?

☐ Yes ☐ No

If yes, is the thrombocytopenia caused by treatment for another hematologic or lymphatic condition?

☐ Yes ☐ No

If yes, provide the name of the other hematologic or lymphatic condition causing the secondary thrombocytopenia: _____

If the Veteran has thrombocytopenia, select the answer that best represents the Veteran's condition:

- ☐ Stable platelet count of 100,000 or more
- ☐ Stable platelet count between 70,000 and 100,000
- ☐ Platelet count between 20,000 and 70,000
- ☐ Platelet count of less than 20,000
- ☐ With active bleeding
- ☐ Other, describe: _____

c. Does the Veteran have any complications or residuals of treatment requiring transfusion of platelets or red blood cells?

☐ Yes ☐ No

If yes, indicate frequency of transfusions in the past 12 months:

- ☐ None
- ☐ At least once per year but less than once every 3 months
- ☐ At least once every 3 months
- ☐ At least once every 6 weeks

5. Findings, signs and symptoms

Does the Veteran currently have any findings, signs and symptoms due to a hematologic or lymphatic disorder or to treatment for a hematologic or lymphatic disorder?

☐ Yes ☐ No

If yes, check all that apply:

- ☐ Weakness
If checked, describe: _____
- ☐ Easy fatigability
If checked, describe: _____
- ☐ Light-headedness
If checked, describe: _____
- ☐ Shortness of breath
If checked, describe: _____
- ☐ Headaches
If checked, describe: _____
- ☐ Dyspnea on mild exertion
If checked, describe: _____
- ☐ Dyspnea at rest
If checked, describe: _____
- ☐ Tachycardia
If checked, describe: _____
- ☐ Syncope
If checked, describe: _____
- ☐ Cardiomegaly
- ☐ High output congestive heart failure
- ☐ Other, describe: _____

6. Recurring infections

Does the Veteran currently have recurring infections attributable to any conditions, complications or residuals of treatment for a hematologic or lymphatic disorder?

☐ Yes ☐ No

If yes, indicate frequency of infections over past 12 months:

- ☐ None
- ☐ At least once per year but less than once every 3 months
- ☐ At least once every 3 months
- ☐ At least once every 6 weeks

7. Polycythemia vera

Does the Veteran have polycythemia vera?

☐ Yes ☐ No

If yes, check all that apply:

- ☐ Stable, with or without continuous medication
- ☐ Requiring phlebotomy
- ☐ Requiring myelosuppressant treatment
- ☐ Other, describe: _____

NOTE: If there are complications due to polycythemia vera such as hypertension, gout, stroke or thrombotic disease, ALSO complete appropriate Questionnaire for each condition.

8. Sickle cell anemia

Does the Veteran have sickle cell anemia?

☐ Yes ☐ No

If yes, check all that apply:

- ☐ Asymptomatic
- ☐ In remission
- ☐ With identifiable organ impairment
- ☐ Following repeated hemolytic sickling crises with continuing impairment of health
- ☐ Painful crises several times a year
- ☐ Repeated painful crises, occurring in skin, joints, bones or any major organs
- ☐ With anemia, thrombosis and infarction
- ☐ Symptoms preclude other than light manual labor
- ☐ Symptoms preclude even light manual labor
- ☐ Other, describe: _____

9. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

☐ Yes ☐ No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

☐ Yes ☐ No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs and/or symptoms?

☐ Yes ☐ No

If yes, describe (brief summary): _____

10. Diagnostic testing

If testing has been performed and reflects Veteran's current condition, no further testing is required. When appropriate, provide most recent complete blood count.

a. Has laboratory testing been performed?

☐ Yes ☐ No

If yes, provide results:

Hemoglobin (gm/100ml): _____

Date: _____

Hematocrit: _____

Date: _____

Red blood cell (RBC) count: _____

Date: _____

White blood cell (WBC) count: _____

Date: _____

White blood cell differential count: _____

Date: _____

Platelet count: _____

Date: _____

b. Are there any other significant diagnostic test findings and/or results?

☐ Yes ☐ No

If yes, provide type of test or procedure, date and results (brief summary): _____

11. Functional impact

Do the Veteran's hematologic or lymphatic condition(s) impact his or her ability to work?

☐ Yes ☐ No

If yes, describe impact of each of the Veteran's hematologic and lymphatic conditions, providing one or more examples: _____

12. Remarks, if any: _____

Physician signature: _____ Date: _____

Physician printed name: _____

Medical license #: _____ Physician address: _____

Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

6.3. Persian Gulf and Afghanistan Infectious Diseases Disability Benefits Questionnaire

Name of patient/Veteran: _____ SSN: _____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

NOTE: This questionnaire is intended solely for claims based on 38 CFR 3.317(c) *Presumptive service connection for infectious disease*. Therefore, this questionnaire should only be completed for Veterans who have or have had one or more of the following diseases/infections of the following agents: brucellosis, campylobacteriosis (*Campylobacter jejuni*), Q-fever (*Coxiella burnetii*), malaria, tuberculosis (*Mycobacterium tuberculosis*), nontyphoid *Salmonella*, shigellosis (*Shigella*), visceral leishmaniasis, or West Nile virus.

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with any of the infectious diseases listed above?

☐ Yes ☐ No

If yes, indicate the infectious disease(s)/agent(s) that the Veteran now has or has been diagnosed with:

<input type="checkbox"/> brucellosis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> <i>Campylobacter jejuni</i>	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> <i>Coxiella burnetii</i> (Q-fever)	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> malaria	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> nontyphoid <i>Salmonella</i>	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> <i>Shigella</i>	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> visceral leishmaniasis	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> West Nile virus	ICD code: _____	Date of diagnosis: _____
<input type="checkbox"/> <i>Mycobacterium tuberculosis</i> (TB) If TB is the only diagnosis checked, do not complete the rest of this Questionnaire; instead, complete the Tuberculosis Questionnaire.		

If any other disease(s) have been checked along with *mycobacterium tuberculosis*, complete the Tuberculosis Questionnaire for all tuberculosis-related conditions, and also complete this Questionnaire (Persian Gulf and Afghanistan Infectious Diseases) for all other non-tuberculosis related diseases checked above.

2. Medical history for disease #1

a. Name of disease #1: _____

Describe the history (including onset and course) of the Veteran's disease #1: _____

b. Status of disease #1:

☐ Active
☐ Inactive/treated and resolved

c. If inactive, date disease became inactive/resolved: _____

d. If inactive/resolved, are there residuals due to the disease?

☐ Yes ☐ No

If yes, describe residuals: _____

Also complete appropriate Questionnaire for each specific residual condition, if indicated.

3. Medical history for disease #2

a. Name of disease #2: _____

Describe the history (including onset and course) of the Veteran's disease #2: _____

b. Status of disease #2:

☐ Active

☐ Inactive/treated and resolved

c. If inactive, date disease became inactive/resolved: _____

d. If inactive/resolved, are there residuals due to the disease?

☐ Yes ☐ No

If yes, describe residuals: _____

Also complete appropriate Questionnaire for each specific residual condition, if indicated.

4. Medical history for disease #3

a. Name of disease #3: _____

Describe the history (including onset and course) of the Veteran's disease #3: _____

b. Status of disease #3:

☐ Active

☐ Inactive/treated and resolved

c. If inactive, date disease became inactive/resolved: _____

d. If inactive/resolved, are there residuals due to the disease?

☐ Yes ☐ No

If yes, describe residuals: _____

Also complete appropriate Questionnaire for each specific residual condition, if indicated.

5. Additional Gulf War infectious diseases

If the Veteran has had any additional Gulf War infectious diseases, describe using above format: _____

6. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

☐ Yes ☐ No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

☐ Yes ☐ No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?

☐ Yes ☐ No

If yes, describe (brief summary): _____

7. Diagnostic testing

NOTE: If the Veteran has had diagnostic testing for suspected or confirmed Gulf War infectious diseases and the results are in the medical record and reflect the Veteran's current status, repeat testing is not indicated.

Are there any significant diagnostic test findings and/or results?

☐ Yes ☐ No

If yes, provide type of test or procedure, date and results (brief summary): _____

8. Functional impact

Does the Veteran's Gulf War infectious disease(s) impact his or her ability to work?

☐ Yes ☐ No

If yes, describe impact of each of the Veteran's Gulf War infectious diseases, providing one or more examples:

9. Remarks, if any: _____

Physician signature: _____ Date: ____

Physician printed name: _____

Medical license #: _____ Physician address: _____

Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

6.4. Tuberculosis Disability Benefits Questionnaire

Name of patient/Veteran: _____ SSN: _____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Diagnosis

a. Does the Veteran now have or has he/she ever been diagnosed with active or latent tuberculosis (TB)?

☐ Yes ☐ No

b. If no, has the Veteran had a positive skin test for TB without active disease?

☐ Yes ☐ No

c. If no, has the Veteran had a positive quantiferon-TB gold test without active disease?

☐ Yes ☐ No

If yes to either question a, b or c above, provide only diagnoses that pertain to TB conditions:

Diagnosis #1: _____

ICD code: _____

Date of diagnosis: _____

Diagnosis #2: _____

ICD code: _____

Date of diagnosis: _____

Diagnosis #3: _____

ICD code: _____

Date of diagnosis: _____

If there are additional diagnoses that pertain to TB, list using above format: _____

2. Medical history

a. Describe the history (including onset and course) of the Veteran's TB condition (brief summary): _____

b. Is the Veteran undergoing treatment or has he or she completed treatment for a TB condition, including active TB, positive skin test or laboratory evidence of TB (positive quantiferon-TB gold test) without active disease?

☐ Yes ☐ No

If yes, complete the following:

Date treatment began: _____

If completed, date of completion: _____

If not completed, anticipated date of completion: _____

c. List medications currently or previously used for treatment of TB condition: _____

3. Pulmonary TB

a. Does the Veteran now have or has he or she ever been diagnosed with pulmonary tuberculosis?

☐ Yes ☐ No

If yes, is the condition:

☐ Active

☐ Inactive

If inactive, date condition became inactive: _____

b. Does the Veteran have any residual findings, signs and/or symptoms due to pulmonary TB?

☐ Yes ☐ No

If yes, indicate residuals:

☐ Emphysema

☐ Dyspnea on exertion

☐ Requires oxygen therapy

☐ Episodes of acute respiratory failure

☐ Moderately advanced lesions

☐ Far advanced lesions (diagnosed at any time while the disease process was active)

☐ Pulmonary hypertension

☐ Right ventricular hypertrophy

☐ Cor pulmonale (right heart failure)

☐ Impairment of health

If checked, describe: _____

☐ Other, describe: _____

c. Has the Veteran had thoracoplasty due to TB?

☐ Yes ☐ No Date of procedure: _____

If yes, has the Veteran had resection of any ribs incident to thoracoplasty?

☐ Yes ☐ No

If yes, indicate number of ribs involved: ☐ 1 ☐ 2 ☐ 3 or 4 ☐ 5 or 6 ☐ More than 6

4. Non-pulmonary TB

a. a. Does the Veteran now have or has he or she ever been diagnosed with non-pulmonary tuberculosis?

☐ Yes ☐ No

If yes, check all non-pulmonary TB conditions that apply:

☐ Tuberculous pleurisy

☐ Tuberculous peritonitis

☐ Tuberculosis meningitis

☐ Skeletal TB

☐ Genitourinary TB

☐ Gastrointestinal TB

☐ Tuberculous lymphadenitis

☐ Cutaneous TB

☐ Ocular TB

☐ Other, describe: _____

b. For all checked conditions, indicate whether the condition is active or inactive; if inactive, provide date condition became inactive: _____

c. Does the Veteran have any residuals from any of the above non-pulmonary TB conditions?

☐ Yes ☐ No

If yes, describe: _____

ALSO complete appropriate Questionnaires for the specific residual conditions.

5. Other pertinent physical findings, complications, conditions, signs and/or symptoms

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section above?

☐ Yes ☐ No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

☐ Yes ☐ No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?

☐ Yes ☐ No

If yes, describe (brief summary): _____

6. Diagnostic testing

NOTE: If test results are in the medical record and reflect the Veteran's current respiratory condition, repeat testing is not required.

a. Have imaging studies or procedures been performed?

☐ Yes ☐ No

If yes, check all that apply:

☐ Chest x-ray

Date: _____ Results: _____

☐ Magnetic resonance imaging (MRI)

Date: _____ Results: _____

☐ Computed tomography (CT)

Date: _____ Results: _____

☐ High resolution computed tomography to evaluate interstitial lung disease such as asbestosis (HRCT)

Date: _____ Results: _____

☐ Other: _____

Date: _____ Results: _____

b. Has pulmonary function testing (PFT) been performed?

☐ Yes ☐ No

If yes, do PFT results reported below reflect the Veteran's current pulmonary function?

☐ Yes ☐ No

c. Pulmonary function testing is not required in all instances. If PFTs have not been completed, provide reason:

☐ Veteran requires outpatient oxygen therapy

☐ Veteran has had 1 or more episodes of acute respiratory failure

☐ Veteran has been diagnosed with cor pulmonale, right ventricular hypertrophy or pulmonary hypertension

☐ Veteran has had exercise capacity testing and results are 20 ml/kg/min or less

☐ Other, describe: _____

d. PFT results

Date: _____

Pre-bronchodilator:

FEV-1: _____ % predicted

FVC: _____ % predicted

FEV-1/FVC: _____ % predicted

DLCO: _____ % predicted

Post-bronchodilator, if indicated:

FEV-1: _____ % predicted

FVC: _____ % predicted

FEV-1/FVC: _____ % predicted

DLCO: _____ % predicted

e. Which test result most accurately reflects the Veteran's current pulmonary function?

☐ FEV-1

☐ FEV-1/FVC

☐ FVC

☐ DLCO

f. If post-bronchodilator testing has not been completed, provide reason:

- ☐ Pre-bronchodilator results are normal
- ☐ Post-bronchodilator testing not indicated for Veteran's condition
- ☐ Post-bronchodilator testing not indicated in Veteran's particular case
- If checked, provide reason: _____
- ☐ Other, describe: _____

g. If Diffusion Capacity of the Lung for Carbon Monoxide by the Single Breath Method (DLCO) testing has not been completed, provide reason:

- ☐ Not indicated for Veteran's condition
- ☐ Not indicated in Veteran's particular case
- ☐ Not valid for Veteran's particular case
- ☐ Other, describe: _____

h. Does the Veteran have multiple respiratory conditions?

☐ Yes ☐ No

If yes, list conditions and indicate which condition is predominantly responsible for the limitation in pulmonary function, if any limitation is present: _____

i. Has exercise capacity testing been performed?

☐ Yes ☐ No

If yes, complete the following:

- ☐ Maximum exercise capacity less than 15 ml/kg/min oxygen consumption (with cardiac or respiratory limitation)
- ☐ Maximum oxygen consumption of 15 – 20 ml/kg/min (with cardiorespiratory limit)

j. Are there any other significant diagnostic test findings and/or results?

☐ Yes ☐ No

If yes, provide type of test or procedure, date and results (brief summary): _____

7. Functional impact

Does the Veteran's tuberculosis condition impact his or her ability to work?

☐ Yes ☐ No

If yes, describe impact of each of the Veteran's tuberculosis conditions, providing one or more examples: _____

8. Remarks, if any: _____

Physician signature: _____ Date: _____

Physician printed name: _____

Medical license #: _____ Physician address: _____

Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

6.5. Eating Disorders Disability Benefits Questionnaire

Name of patient/Veteran: _____ SSN: _____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

NOTE: If the Veteran experiences a mental health emergency during the interview, please terminate the interview and obtain help, using local resources as appropriate. You may also contact the Veterans Crisis Line at 1-800-273-TALK (8255). Stay on the Crisis Line until help can link the Veteran to emergency care.

NOTE: In order to conduct an initial examination for eating disorders, the examiner must meet one of the following criteria: a board-certified or board-eligible psychiatrist; a licensed doctorate-level psychologist; a doctorate-level mental health provider under the close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; a psychiatry resident under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; or a clinical or counseling psychologist completing a one-year internship or residency (for purposes of a doctorate-level degree) under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist.

In order to conduct a REVIEW examination for eating disorders, the examiner must meet one of the criteria from above, OR be a licensed clinical social worker (LCSW), a nurse practitioner, a clinical nurse specialist, or a physician assistant, under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist.

1. Diagnosis

Does the Veteran now have or has he/she ever been diagnosed with an eating disorder(s)?

☐ Yes ☐ No

If no, provide rationale (e.g., Veteran does not currently have any diagnosed eating disorders):

If yes, check all diagnoses that apply:

☐ Bulimia

Date of diagnosis: _____

ICD code: _____

Name of diagnosing facility or clinician: _____

☐ Anorexia

Date of diagnosis: _____

ICD code: _____

Name of diagnosing facility or clinician: _____

☐ Eating disorder not otherwise specified

Date of diagnosis: _____

ICD code: _____

Name of diagnosing facility or clinician: _____

2. Medical history

Describe the history (including onset and course) of the Veteran's eating disorder (brief summary):

3. Findings

NOTE: For VA purposes, an incapacitating episode is defined as a period during which bedrest and treatment by a physician are required.

- ☐ Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder but without incapacitating episodes
- ☐ Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder and incapacitating episodes of up to two weeks total duration per year
- ☐ Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of more than two but less than six weeks total duration per year
- ☐ Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of six or more weeks total duration per year
- ☐ Self-induced weight loss to less than 80 percent of expected minimum weight, with incapacitating episodes of at least six weeks total duration per year, and requiring hospitalization more than twice a year for parenteral nutrition or tube feeding

4. Other symptoms

Does the Veteran have any other symptoms attributable to an eating disorder?

☐ Yes ☐ No

If yes, describe: _____

5. Functional impact

Does the Veteran's eating disorder(s) impact his or her ability to work?

☐ Yes ☐ No

If yes, describe impact, providing one or more examples:

6. Remarks, if any: _____

Psychiatrist/Psychologist signature & title: _____ Date: _____

Psychiatrist/Psychologist printed name: _____

License #: _____ Psychiatrist/Psychologist address: _____

Phone: _____ Fax: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

6.6. Medical Opinion Disability Benefits Questionnaire

MEDICAL OPINION (to be completed by the examiner)

Name of patient/Veteran: _____ SSN: _____

Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

1. Definitions

Aggravation of preexisting nonservice-connected disabilities. A preexisting injury or disease will be considered to have been aggravated by active military, naval, or air service, where there is an increase in disability during such service, unless there is a specific finding that the increase in disability is due to the natural progress of the disease.

Aggravation of nonservice-connected disabilities. Any increase in severity of a nonservice-connected disease or injury that is proximately due to or the result of a service-connected disease or injury, and not due to the natural progress of the nonservice-connected disease, will be service connected.

2. Evidence review

Was the Veteran's VA claims file reviewed?

☐ Yes ☐ No

If yes, list any records that were reviewed but were not included in the Veteran's VA claims file:

If no, check all records reviewed:

- ☐ Military service treatment records
- ☐ Military service personnel records
- ☐ Military enlistment examination
- ☐ Military separation examination
- ☐ Military post-deployment questionnaire
- ☐ Department of Defense Form 214 Separation Documents
- ☐ Veterans Health Administration medical records (VA treatment records)
- ☐ Civilian medical records
- ☐ Interviews with collateral witnesses (family and others who have known the veteran before and after military service)
- ☐ No records were reviewed
- ☐ Other: _____

Complete only the sections below that you are asked to complete in the Medical Opinion DBQ request.

3 Medical opinion for direct service connection

Choose the statement that most closely approximates the etiology of the claimed condition.

- a. ☐ The claimed condition was at least as likely as not (50 percent or greater probability) incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in section c.
- b. ☐ The claimed condition was less likely than not (less than 50 percent probability) incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in section c.

c. Rationale:

4 Medical opinion for secondary service connection

a. ☐ The claimed condition is at least as likely as not (50 percent or greater probability) proximately due to or the result of the Veteran's service connected condition. Provide rationale in section c.

b. ☐ The claimed condition is less likely than not (less than 50 percent probability) proximately due to or the result of the Veteran's service connected condition. Provide rationale in section c.

c. Rationale:

5. Medical opinion for aggravation of a condition that existed prior to service

a. ☐ The claimed condition, which clearly and unmistakably existed prior to service, was aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in section c.

b. ☐ The claimed condition, which clearly and unmistakably existed prior to service, was clearly and unmistakably not aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in section c.

c. Rationale:

6. Medical opinion for aggravation of a nonservice connected condition by a service connected condition

a. Can you determine a baseline level of severity of (claimed condition/diagnosis) based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by (service connected condition)?

☐ Yes ☐ No

If "Yes" to question 6a, answer the following:

- i. Describe the baseline level of severity of (claimed condition/diagnosis) based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by (service connected condition):

ii. Provide the date and nature of the medical evidence used to provide the baseline: _____

iii. Is the current severity of the (claimed condition/diagnosis) greater than the baseline?

☐ Yes ☐ No

If yes, was the Veteran's (claimed condition/diagnosis) at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?

☐ Yes (provide rationale in section b.)

☐ No (provide rationale in section b.)

If "No" to question 6a, answer the following:

- i. Provide rationale as to why a baseline cannot be established (e.g. medical evidence is not sufficient to support a determination of a baseline level of severity): _____
- ii. Regardless of an established baseline, was the Veteran's (claimed condition/diagnosis) at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?
- ☐ Yes (provide rationale in section b.)
- ☐ No (provide rationale in section b.)

b. Provide rationale:

7. Opinion regarding conflicting medical evidence

I have reviewed the conflicting medical evidence and am providing the following opinion:

Physician signature: _____ Date: _____

Physician printed name: _____ Phone: _____

Medical license #: _____ Physician address: _____

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

7. Software and Documentation Retrieval

7.1 Software

The VistA software is being distributed as a PackMan patch message through the National Patch Module (NPM). The KIDS build for this patch is DVBA*2.7*166.

7.2 User Documentation

The user documentation for this patch may be retrieved directly using FTP. The preferred method is to FTP the files from:

REDACTED

This transmits the files from the first available FTP server. Sites may also elect to retrieve software directly from a specific server as follows:

OI&T Field Office	FTP Address	Directory
Albany	REDACTED	[anonymous.software]
Hines	REDACTED	[anonymous.software]
Salt Lake City	REDACTED	[anonymous.software]

File Name	Format	Description
DVBA_27_P166_RN.PDF	Binary	Release Notes
DVBA_27_P166_DBQ_EATINGDISORDERS_WF.DOC	Binary	Workflow document
DVBA_27_P166_DBQ_HEARINGLOSS_WF.DOC	Binary	Workflow document
DVBA_27_P166_DBQ_HEMICANDLYMPHATIC_WF.DOC	Binary	Workflow document
DVBA_27_P166_DBQ_MEDICALOPINION_WF.DOC	Binary	Workflow document
DVBA_27_P166_DBQ_PGINFECTDISEASES_WF.DOC	Binary	Workflow document
DVBA_27_P166_DBQ_TUBERCULOSIS_WF.DOC	Binary	Workflow document

7.3 Related Documents

The VistA Documentation Library (VDL) web site will also contain the DVBA*2.7*166 Release Notes and related workflow documents. This web site is usually updated within 1-3 days of the patch release date.

The VDL web address for CAPRI documentation is: <http://www.va.gov/vdl/application.asp?appid=133>.